CHILD HEALTH HISTORY FORM

Front and back to be completed

Mail this form to:
Pioneer Camp & Retreat Center, Inc.
9324 Lake Shore Road
Angola NY 14006

Camper Name: _____
First Middle Last

Dates attending camp: from _____ to _____
Month/Day/Year Month/Day Year

Male Female Birth Date _____ Age on arrival at Camp: _____

To Parent(s) /Guardian(s):
This form MUST be returned at least 14 days prior to arrival at camp!

Camper Name: Please Print First Middle Last Camp Date:

THIS FORM IS REQUIRED FOR CAMPERS ATTENDING DISCOVERY, YOUTH, TEEN, YVL, CONFIRMAND, PAPYRUS OR MILITARY YOUTH PROGRAMS

Camper Home Address: _____
Mailing Address City State Zip

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship to Camper: _____ Preferred Phones: (_____) _____

Email: _____ (_____) _____

Home Address :_____
(If different from above) Mailing Address City State Zip

Second parent/guardian or other emergency contact:

Name:_____ Relationship to Camper:_____ Preferred Phones: (_____) _____

Email: _____ (_____) _____

Allergies: No known allergies This camper is allergic to: Food Medicine
The environment (insect stings, hay fever, etc.) Other

Describe what the camper is allergic to and the reaction seen.

Diet & Nutrition: This camper eats a regular diet. This camper eats a regular vegetarian diet.
This camper has special food needs. **Describe dietary needs.**

Restrictions: I have reviewed the program and activities of the camp and feel the camper can participate without restrictions.
I have reviewed the program and activities of the camp and feel the camper can participate with the following restrictions or adaptations. **Describe any and all restrictions.**

Medical Insurance Information:
This camper is covered by family medical/hospital insurance Yes No

Include a copy of your insurance card; copy on both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____) _____

Immunization History: Required for attendance!

Immunization Record **MUST** be attached to this medical form.

Health-Care Providers:

Name of camper's primary doctor(s):_____Phone (_____) _____

Name of dentist(s):_____ Phone (_____) _____

Name of orthodontist(s):_____ Phone (_____)_____

Mental, Emotional, and Social Health: Check "Yes or "No" for each statement. Has the camper:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ……..	Yes	No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? …….....	Yes	No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ……..	Yes	No
4. Had a significant life event that continues to affect the camper's life? ……	Yes	No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)

Explain "Yes" answers here, noting the question number. The camp may contact you for additional information.

General Health History: Has/does the camper:

1. Ever been hospitalized?	Yes	No	11. Had fainting or dizziness?	Yes	No
2. Ever had surgery?	Yes	No	12. Passed out/had chest pain during exercise?	Yes	No
3. Have recurrent/chronic illnesses?	Yes	No	13. Had mononucleosis ('mono") during past 12 months?	Yes	No
4. Had a recent infectious disease?	Yes	No	14. If female, have problems with periods/menstruation?	Yes	No
5. Had a recent injury?	Yes	No	15. Have problems with falling a sleep/sleepwalking?	Yes	No
6. Had asthma/wheezing/shortness of breath?	Yes	No	16. Ever had back/joint problems?	Yes	No
7. Have diabetes?	Yes	No	17. Have a history of bedwetting?	Yes	No
8. Had Seizures?	Yes	No	18. Have problems with diarrhea/constipation?	Yes	No
9. Had headaches?	Yes	No	19. Have any skin problems?	Yes	No
10.Wear glasses, contacts, or protective eyewear?	Yes	No	20. Traveled outside the U.S. in the past 9 months?	Yes	No

Parent/Guardian Authorization for Health Care:

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff and health care provider(s). I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with camp staff about my child's health status.

I realize I may also receive a call from a healthcare provider for further information and consent to treat.

Signature of Custodial Parent/Guardian_____Date_____ Relationship to Camper:_____

First Last